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Bulletin of
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TOMORROW'S PSYCHIATRIST

BY ELI GINZBERG*

It is unbecoming—in fact, improper—for an outsider to enter upon discussions of the educational policies of a profession to which he does not belong. When these discussions relate to a specialized group within the profession, the impropriety is heightened. Cognizant of these truisms, I shall make every effort in this short essay to stay within bounds. My remarks will keep far afield from general considerations of medical education and will likewise avoid the many complex areas which relate to training in psychiatric research and therapy.

Psychiatry—broadly defined— is more than a medical specialty. It contains within itself great potentialities for broadening our knowledge, not only of the sick man but of healthy communities and nations; it can strengthen the base of moral and ethical theory; above all it can contribute greatly to improving the mechanics of social reform.

The new vistas of productive work are but dimly outlined. The developments of the last hundred years have been in other directions. Psychiatry has made great strides in understanding many hitherto obscure realms of the human mind and its infinite vagaries. It has made important advances in coping more intelligently and effectively with patients suffering from psychiatric disorders. But the cautious critic cannot dispel the feeling that despite this very real progress, psychiatry is still in its infancy as regards problems of pathology and therapy. There are still so many important factors which remain uncorrelated, so much behavior that defies comprehension. Therapy, too, remains circumscribed. The seriously ill can be made more comfortable—that is about all. New advances in psychotherapy augur well for a successful attack on a large area of hitherto intractable conditions. We are probably only at the beginning of shock treatment, sedation, and many new approaches. But extreme optimism is surely out of place.

If progress has been slow in coping with the psychotic and the other seriously ill, advances have not been striking in dealing effectively with that more numerous group of psychoneurotics. Psychoanalysis has its limitations beyond the costs of patient and doctor time. The less intensive therapeutic approaches have even more serious drawbacks.

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To the outsider looking in, psychiatry has come a "fur piece," but it is really at the beginning of the trail—and the road ahead is uncharted. But some sense of direction can be secured if not from psychiatry, then from allied branches of medicine. It is generally recognized that for every gain in individual therapy there has been a ten- or hundred-fold gain in preventive medicine. Even during the current war, the many advances in traumatic surgery will probably be overshadowed by a simple powder—DDT—which can so effectively cope with so many of the enemies of man. Without falling into false dichotomies, it is to preventive rather than to therapeutic psychiatry that one must look for the most startling advances in the coming decades.

Once the psychiatrist admits that much of his work will have to be done outside the four walls of his consulting room, it behooves him to consider carefully the setting in which he will operate. The competent epidemiologist never goes far afield without consultation, probably collaboration with his engineering confreres. His problems can usually be solved only by tempering the discoveries of the medical laboratory to the practicalities of the engineering world. The psychiatrist who is concerned with preventive measures must, therefore, review and appraise the media through which he must work.

Without establishing an exhaustive list, four major institutions can be enumerated of primary concern for preventive psychiatry as of the present moment: the church, the school, the Army, industry. These are the cauldrons in which the minds of successive generations are shaped. To this list must be added, of course, the most important and elusive of all—the family. The approach to the family will always be circuitous—through the physician, the social agency, the adult educational group.

The way of a psychiatrist is cut out for him. If his lessons are to be learned, he must find instructors to teach and practice. The family physician and the minister must not be neglected. Equally important is the school teacher and the captain of a training battalion. Employers also are worth cultivating.

It is very much of a paradox that the offerings of psychiatry were spurned by the medical profession for a considerable time and even at this late date the former negativism has not really been dissipated. But if psychiatry is to broaden its field of endeavor, it must win the wholehearted support, if not of this, then of the next generation of doctors. Even in this day of specialization, the family physician remains a potent influence. He serves not only as the healer of the sick but also as the confessor to the troubled. As practicing physician, he should be psychiatrically minded; as confessor, he must be. One battle that psychiatry must win is in the medical schools of the country. It is apparently making progress, but a renewed drive is overdue.

Much is said about the waning influence of religion, and much of what is said can be documented. But it would be an error of serious proportions to neglect the ministry in seeking assistants. For the tens of thousands who have no membership in a church, there are millions who do. Every day, ministers of every faith are working to condition the attitudes and feelings of their parishioners. What is more, they spend a considerable time in psychiatric consultation. It may be only a visit to ill Mrs. Jones or a few words with Tom who has not been around to church for several months—but whatever the precipitating cause, actually these parish duties are practical psychiatry. Some theological schools have made a place for psychiatry in their curriculum, but not many. Clearly, work along this front must be pushed aggressively if one of the potentially strongest allies is not to be lost and turn into an unfriendly non-belligerent if not an active enemy.

Family physicians and ministers have their work cut out largely with adults. But if preventive psychiatry is to make progress as speedily as possible, it will concentrate on children, especially younger children. This means that the approach to school teachers becomes of paramount importance. Not only must psychiatric training be an integral part of the curriculum of every normal school, but child guidance clinics should be a part of practical demonstrations, their operations and value understood by all who go out to teach.

According to the best psychiatric doctrine, late adolescence and early adulthood offer much more serious obstacles to correcting a skewed personality than does early childhood. But if the job is not done before ten, there is no reason to sidestep it at twenty. Military training is here probably to stay, at least for a long while to come. Every 18-year-old male will be screened for military service, and the vast majority accepted. The screening process will present a unique opportunity to spot individuals in need of psychiatric assistance. Knowlege of their number, a catalogue of their conditions will not provide an answer to effective therapy but will at least contribute to focusing the problem. Moreover, well-indoctrinated officers and non-commissioned men will be able to contribute to improving the emotional stability of large numbers of selectees for whom the Army will represent the first break with home, the first real adult challenge that must be met.

Except for a few millionaires and a few relief clients, most men and an increasing number of women live the greater part of their adult years under the dictates of their job. The competition of the market place is frequently intense. Sheer survival is difficult; satisfactory adjusments rare. Yet, individuals have differing talents and differing aspirations. The wrong man in a good job cannot be a happy man; and the right man in a poor job likewise cannot be a happy man. Perhaps most men cannot be

happy in their work. A great many can if industry learns that mal-assignments leading to friction and frustration are frequently correctible. Psychiatry has much to offer modern industry. A few concerns are aware of this fact; the vast majority are completely oblivious to the problem or the cure.

The psychiatrist has come out of his consulting room. But is he able to operate successfully on the faculties of theological and educational institutions? Can he communicate effectively with the technically-minded military man and the profit-preoccupied industrialist? In short, is the psychiatrist able to venture forth on an expanded program of preventive- and therapeutic-psychiatry with the training which he has received to date? The answer must be an unequivocal "No!"

To work through the specific problem of a patient in the consulting room almost always involves a careful and detailed reconstruction and evaluation of the individual's life's history. If psychiatry is to go afield and work through established social organizations and through the leadership of these organizations, psychiatrists cannot escape the obligation of understanding the highways and byways of these important institutions. No more pithy illustration of the inadequate training of present-day psychiatrists for tomorrow's work can be offered than the recital of a recent incident when a competent psychiatrist branching out to deal with the analysis of a nation, approached a professor of history on the prospects of collaboration with the suggestion that he would contribute the psychiatry if the professor would furnish the historical details!

The history of our own society and what is equally important, if only to avoid unwarranted generalizations, the history of other societies must be part of the equipment of every psychiatrist whose preoccupation will extend beyond the asylum's fence or the analytic couch.

The life of men in groups is the most complicated of all forms of life. It is not easily understood. But it must be studied and evaluated if the psychiatric specialist is to influence effectively men in other pursuits.

Values are the concern of all thinking men. No one individual or group of individuals can monopolize the field. The search for the good, the recognition and avoidance of evil has a venerable history which began with the first religious teacher and will continue until the last philosopher has died. There is much that psychiatry can contribute to the never-solved problem of human happiness. But its contribution cannot even get a hearing in court unless its advocates are schooled in the ways of the court. From Plato to Bergson and Croce is a long way. The many significant books written by the best minds of all ages must be not only read but studied before a proper place can be found in the tradition for the psychiatric insights, perhaps even truths, of today.

Philosophy and history are definite requisites for tomorrow's psychiatrists. No amount of pathology and neurology can be substituted. Equally, if not more important, is training in scientific method—in working up data and testing results which would permit the critic to distinguish insight from truth. Modern statistics in its broadest implications should be a "must" for all who are trained today. The western scientific world from physics through sociology adheres to certain canons of logic and procedure. Psychiatry cannot come into the fold and at the same time stay out. Psychiatrists must be trained so that they can distinguish the interesting case history from a valid generalization.

To accomplish their expanded mission, psychiatrists must not only win the tolerance of parents, educators, theologians, military men, labor leaders and industrialists, but they must gain their active support. This will be at best a task of great difficulty. To the extent that psychiatrists improve and increase the tools in their kit, they have a chance of succeeding. They need help.

Universities are uncertain as to their next move; foundations are undecided as to the worthwhileness of competing requests for assistance. Two things are clear: Universities should realize that psychiatry is more than a medical specialty to be sandwiched in between medicine and neurology. Psychiatry is of concern to other than medical students. Recognizing these facts, universities should act accordingly and establish psychiatry as one of the strategic psychological disciplines which can contribute to and advance by close association with allied branches of learning.

Hand in hand with university status should come the foundation grants for training of personnel and the pursuit of research without which every discipline will atrophy. As long as the future of psychiatry must depend on the contributions of harassed practitioners just so long will the promise of preventive psychiatry and all that it implies remain unfulfilled. The lesson of medicine itself permits of no doubt that the future of science depends on scientists, not on practitioners. This fact is recognized among the leaders of higher education. It is their obligation to apply it to psychiatry.

PSYCHIATRY IN UNDERGRADUATE MEDICAL EDUCATION

By JOHN ROMANO, M.D.*

It is generally assumed that there are two principal objectives of undergraduate medical education. One is the attainment by the student of knowledge of the fundamental principles of human biology; the other is the development of the capacity to apply this knowledge intelligently to the prevention of illness and to the study and care of sick persons. Further it is assumed that the acquirement of more specialized knowledge, skills or techniques is dependent upon the experiences and training of the student beyond the undergraduate period. What part should the discipline of modern psychiatry play in the undergraduate period of medical education? Certainly it will not be possible for undergraduate psychiatry to prepare each physician to use efficiently all of the special skills or techniques in the field.

If we keep in mind these two principal objectives of undergraduate medical education, it becomes clear that psychiatry should attempt to equip the student with a reasonable knowledge of the basic facts of human nature and should, through repetitive clinical experience, familiarize the student with the most common and the most important emotional problems of patients with which he will be confronted later as a physician. Before discussing the objectives, content and method of psychiatric teaching in this period three factors should be considered. The first is the relative importance of psychiatric education in the undergraduate period; the second is the relationship of the teaching program to the other medical disciplines in the undergraduate period; and the third is, the criteria for adequacy of the teachers of psychiatry.

In respect to the first question, the relative importance of psychiatric education, there are a number of people, educators among them, who believe that the increasing concern seems unwarranted, exaggerated, or beyond the responsibility of medicine. In fact, many believe that the knowledge and techniques of psychiatry are so limited and so foreign to current medical thought that the goals attained thus far are as much as one could expect. We believe that there is valid reason not only for concern, but for courageous and sustained action. Even a cursory glance at the modern scene leaves little doubt as to the need for improvement in the form and structure of undergraduate psychiatric education. Two facts seem clear. The first is that the average medical graduate of today appears to have less understanding of "human nature" and of the physiologic and psychologic

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concomitants of the emotional experiences of mankind, such as grief, rage, resentment, fear, and anxiety, than have many informed intelligent lay people. The second fact is that a considerable proportion of the patients who come to the physician are sick in varying ways, not because of toxic or metabolic noxious agents, but because of disturbed human relations. While it is obvious that there are many unwritten pages in the field of psychiatry in relationship to knowledge as well as technique, the fact is apparent to any one who wishes to appreciate it, that modern psychiatry is better prepared today to lead to understanding of human behavior than at any previous time in the history of medicine.

What should be the relationship of undergraduate psychiatry to the other disciplines in this period of study? Obviously no program of study can be thoroughly successful unless there is common understanding and cooperative effort among the teachers of the various disciplines reaching for the same goal; namely, the preparation of the physician who is to study and care for sick persons. Furthermore, the future development of any cooperative effort in the medical school will be dependent to a considerable degree upon the matter of the total medical curriculum. We are aware that there has been no essential change in the basic theoretical structure of the medical curriculum, or in the collegiate preparatory period in the past fifty years. The changes which have taken place relate more to the introduction of new facts and the expansion of existing departmental assignments than to an effort to consider inter-relationships and common goal. In teaching medical students we have found it useful to consider medicine as one of the principal liaison agents between biology and sociology. It is our feeling that while medicine has kept astride of the remarkable contributions of physics and chemistry to human biology, it has fallen behind in its understanding of the impact of social forces in man. It appears to us that there is urgent need for a serious and candid scrutiny of the present status of medical education; a scrutiny to determine what we are doing, what we should be doing and what changes should be effected to achieve the goal we have in mind. The medical student of today appears to be so deluged with bits of precise information that it takes him many years, if then, to be able to evaluate the information and to orient it so that he can use it efficiently and wisely. We have accumulated a considerable amount of evidence to indicate that the medical curriculum in various ways has actually deprived the student of the knowledge of human nature that he had before he came to medical school. I was interested to find a very refreshing and penetrating analysis of this problem by Halliday; he quoted a modern poet who put it, "Where is the knowledge we have lost through information"? [1]

These remarks are not intended to mean that psychiatry should assume

a Messianic role in curricular planning. They are intended simply to express the belief that there is an urgent need for serious consideration and study of the medical curriculum if the purpose of that curriculum is to prepare students to understand sick persons and to care for them intelligently. Further, that no amount of zeal, enthusiasm, or additional courses will lead to the development of an intelligent and successful program of psychiatric undergraduate teaching until many of the formidable interdepartmental barriers are taken down and until there is a clearer understanding of objectives and a cooperative effort among all those who teach medical students.

Who are to be the teachers of psychiatry in the undergraduate period? Obviously, the success of any teaching program is dependent upon a number of variables. One of the them certainly must be the competence of the teacher. Are there enough persons today who are equipped to teach modern psychiatry in the medical schools? The number is limited. The term psychiatrist has had a very broad and general meaning. A psychiatrist may be fairly efficient in one area, let us say the state hopital, but find his experience and knowledge quite useless in the field of medical education. It may not be possible for one person to equip himself with all the skills, techniques and knowledge that are necessary to teach psychiatry to medical students. It should be possible then for such a person, as do professors in other departments, to complement his experiences and knowledge with others in his department who have the complementary skills and knowledge.

The teacher of psychiatry should be one who is first and foremost a capable psychiatrist. This may sound absurd, but the fact remains that many teachers of psychiatry are chosen because of their knowledge, skill or technique in fields other than in psychiatry. Opinions differ as to whether a psychiatrist should be considered to be trained without having had psychoanalytic experience and instruction. I believe such training to be an absolute necessity. The psychiatrist should have a working knowledge of the problems of internal medicine (including neurology), pediatrics and surgery. He should be reasonably familiar with the methods of modern physiology and psychology. He should be able to understand the method, scope and goals of social case work in a community so that he can work efficiently with a caseworker. He should be a good teacher, one who is able to communicate his ideas and experiences to students clearly and simply, and one who is able to stimulate creative thinking in his students.

Unlike the other disciplines in the undergraduate period which deal with the less personal aspects of human biology, psychiatry has an additional problem to face. This is the problem of the personal anxiety of the student

who has to be taught to understand and to treat anxious people. One has to remember that in the preparation of the physician it is not enough that certain factual knowledge and techniques be communicated to him. He must also learn to understand and to treat the anxiety manifestations of his patients without mobilizing unduly his own anxiety. This aspect of his training has for the most part been left to the trial and error experience of repetitive clinical exposure. In psychiatry as in no other discipline the problem reaches considerable proportions. The difficulties encountered by students in reading or listening to case histories and more particularly in attempting to manage the emotional experiences of their patients leads all too often to perplexity and anxiety. These in turn result in punitive attitudes toward or maudlin identifications with patients. Eventually the student becomes resistant to all psychologic experiences, including his own, and embarks on a career of denying the validity of psychologic data.

The method, content and objectives of undergraduate psychiatry today should be different from what they were in the past. The teaching program should be concerned with two major objectives. First, a working knowledge of basic human nature, including some awareness on the part of each student of his own emotional biases and prejudices; and second, repetitive clinical experience with those problems with which the general practitioner is faced constantly. For these reasons we do not intend to devote as much time to the study of the psychoses or the traditional neuroses as was done in the past. We believe that what the student needs to know can be taught to a great degree in the medical, surgical and pediatric wards and dispensaries. Here is where the psychiatrist is able to teach the student to understand and to treat the emotional problems of patients at the level at which they present themselves to the general practitioner. Attention in teaching should be directed more to the somatic expressions or concomitants of emotional illness rather than to the predominantly psychological symptomatology of certain psychotic and neurotic behavior. As a matter of fact, the general practitioner does not see many patients with the latter type of behavior and if he does he usually refers such a patient to a specialist which is what he should do.

The following is an outline of what we believe are the most important areas to be covered in four years of undergraduate psychiatric teaching.

1. The student should be taught certain fundamental concepts of basic human nature. In our experience this has meant that the student should be taught motivational aspects of human behavior, including motivations of which the patient is not aware. It should include the study of forces within and outside the personality which demand gratification, the nature of conflicts which arise in attempting to gratify these needs and the defenses

mobilized to combat the anxiety which results from the conflict. One can illustrate these various aspects with clinical experiences ranging from the rage of a hungry infant to the faint of the patient who anxiously anticipates venepuncture to the compensatory confabulation of an aged person with faulty memory.

2. The student should be taught the normal emotional experiences of sick people. He should also be made aware of his own emotional relationship to his patients. The student should be taught that sickness threatens the security of a person, and that the sick person in some degree withdraws and retires from reality. The degree of withdrawal and of the expression of anxiety is dependent upon the emotional preparation of the patient for his illness and the nature of the medical management as well as upon the acuity and severity of the illness. The difference between the emotional defenses utilized by patients in acute sudden illness should be contrasted with the emotional defenses developed in chronic disease. Attention should be directed to teaching the student the intelligent management of acute and chronic illness and the formidable problems of convalescence and disability. The dynamics of the doctor-patient relationship should be studied and an attempt made to understand hostility and indifference as well as over-valuation in the inter-relationships between physician and patient.

3. The student should be taught that certain patients become ill, not from toxic, metabolic or physical causes, but because of disturbed human relations; that illness, in these instances, is primarily caused by emotional factors. The concept of psychogenesis should be discussed and illustrated by the fundamental theoretical and clinical distinctions between hysterical conversion symptoms, vegetative neuroses and psychogenic organ disease. In the latter two categories, it should be possible to demonstrate the concomitant physiologic changes which accompany sustained or unrelieved emotional tension. He should be taught to understand and not to mismanage the many aspects of behavior problems of children, and the more or less normal sexual and marriage adjustment problems with which he will be faced in the practice of medicine.

4. It is important that the student understand illness associated with or caused by disturbed cerebral metabolism. In this group are the many patients who are experiencing varying degrees of disturbed consciousness, from sleepiness to traditional delirium or coma, and who may be observed at any time on any medical or surgical service. Attention should be directed primarily to the normal physiology and metabolism of the brain, to the methods by which the student can be made aware of the existence of disturbed metabolism, to the nature of the clinical symptomatology and to the intelligent application of physiologic principles to remedy the defect.

Patients with more or less reversible deliria (cardiac failure, drug intoxication, infection, fever, etc.) as well as the less reversible instances of structural cerebral defect (trauma, chronic infection, neoplasm, vascular disease, etc.) may be observed and studied. One should be concerned less with specific clinical reactions to specific noxious factors than with the broad principles of normal and disturbed cerebral metabolism, the subsequent physiologic and psychologic symptomatology and the basis of prevention and treatment.

5. Some classificatory knowedge of diagnostic syndromes is necessary, principally to stimulate the student to develop clinical judgment as to the seriousness of any problem which he may encounter. For example, the symptom of anorexia, not due to physical causes, in an adolescent girl may be a normal concomitant of an evanescent emotional experience, it may be an hysterical symptom, it may be part of the very serious syndrome of anorexia nervosa, or the initial symptom of a schizophrenic personality disintegration. It is necessary to help the student to aggregate the data which, together with his later clinical experiences, will enable him to judge critically not only what is happening but the relative significance of the symptoms.

6. With intimate skilled supervision of students in clinic and seminar study, it should be possible for each student to become aware of some of his more flagrant emotional biases, prejudices and blind spots. It is our belief that this can be achieved much more successfully in small group, section and seminar associations in which the skilled psychiatric teacher can utilize the individual student's reactions to his patient's problems rather than through autobiographic personality inventories which deal principally with remembered past behavior.

7. The undergraduate period should attempt to give the student a reasonable concept of what methods of psychotherapy and in what areas of human distress he is able to operate efficiently and safely. Realistic knowledge of limitations is as important as is awareness of what he can and should do. Furthermore, misconceptions concerning reversibility or irreversibility of emotional illness should be corrected.

We have considered objectives and content of the psychiatric curriculum in the undergraduate period. What are we able to say concerning methods? We believe that psychiatry should be taught in each year of the curriculum. We believe that skilled psychiatrists should be assigned to teaching posts, not as occasional visitors but as intimate coworkers to the other teaching services of the hospital. This is absolutely necessary if the student is to learn how to understand and treat the emotional problems of patients at the level at which he will meet them in the practice of medicine. Students should be assigned to study patients with acute or chronic illness,

those disabled or handicapped, those experiencing convalescence on all the services of a hospital if there is intimate skilled supervision. Certain out-patient departments (pediatrics, gastro-enterology, dermatology) may offer special opportunity. Students should be assigned to psychiatric wards for study of psychotic patients, to psychiatric clinics for further study of patients with neurotic and socially delinquent behavior. Some attempt should be made to acquaint the student with method, scope and and goal of social agencies. Our experience leads us to believe that the most efficient method of teaching is one which provides for small group or section teaching under the supervision of skilled and experienced teachers and with the active and continuous participation of the student. This will mean the necessity of many trained psychiatrists in a department. In addition to the traditional clinical bedside teaching it may be profitable to employ the method of intimate supervision which is used in the training of social case workers and the seminar conferences used by the psychoanalytic training schools. We have used clinical conferences and find them valuable. We do not believe that lectures should be eliminated altogether. They have two great purposes; one in allowing the teacher to outline the scope and area of a field in a panoramic fashion; the other, of clarifying and organizing the interim clinical experiences of the student.

In conclusion, I should like to say that we are far from having final or definitive convictions in respect to the content or method of teaching undergraduate psychiatry. Present limitations of time, trained teachers and the restrictions of the accelerated program are common to all schools. Even in a brief period we have modified our approach a number of times and we intend to continue to modify it whenever we believe it necessary to do so. There is need for continuous thought and experience. At the present time it is difficult to know how much knowledge of psycho-dynamics can be communicated to students, how much of this knowledge is assimilable, and how much of the knowledge the student will be able to use efficiently and wisely. We have no doubt as to the validity and importance of the objectives. If psychiatry in the undergraduate period enables the student to acquire a sound understanding of basic human nature, we believe its principal objective will be fulfilled.

REFERENCES

1. Halliday, J. L.: Principles of Ætiology. *British Journal of Medical Psychology*, 19: 367-380, 1943.

GRADUATE TRAINING IN PSYCHIATRY

By KARL MENNINGER, M.D.

There is an increasingly general recognition of the fact that many more psychiatrists are needed. This implies that more physicians must be trained in psychiatry, either in short courses for psychiatric orientation or in longer formal courses of graduate training in preparation for the full-time practice of the specialty. At the present time there are all too few medical students able to preserve that initial interest in psychiatry which surveys have shown to be most frequently present in the first year classes. But the more deplorable fact is that even for those who maintain or develop an interest in psychiatry at a time when they are technically ready to pursue it, there are not at the present time adequate facilities or plans for such training.

Formal training in the specialties has been generally relegated to certain selected hospitals approved for this purpose by the Council on Medical Education of the American Medical Association. In a vague, unofficial and very unsatisfactory way this approval is concurred in, for psychiatry, by the American Psychiatric Association and the National Committee for Mental Hygiene. The latter has made a study of over 100 of these approved hospitals and has found a wide variation in the training programs and teaching methods. In most of them there is little or no formal program and the resident is left largely to his own devices to acquire such training as he can from such instructors as he can, something in the nature of a loosely supervised apprenticeship. Such an apprenticeship is necessarily molded about the routine work of the hospital and since most of these hospitals are primarily public custodial institutions, the psychiatry acquired by the apprentices is often decidedly limited in scope.

Once this was well enough. Psychiatry was almost synonymous with the state hospital care of the committed "insane." The problems of psychiatry were those of certification, committment, classification, custody, parole and discharge. Later, a few therapeutic measures were introduced and the consideration of selection of patients for such treatments and the application of these treatments enlarged the program slightly. But, in the main, the old psychiatry was institutional psychiatry and institutional psychiatry has never put much premium on treatment. To do it justice one should add that it did put a great deal of emphasis on diagnosis, on individual study and on attitude. *Attitude of the physician toward the patient is still the most important thing to be taught in psychiatry* and it must be conceded that this can be (and has been) well taught in even the most old fashioned of institutions.

But psychiatry today has gone far beyond the institutional phase and hence far beyond the type of training required in too many "approved" hospitals. Psychiatry has become a complex specialty. Its extra-mural applications are far more numerous in point of patients and far more complicated in point of social relationships than was the case with exclusively hospital psychiatry. Out-patient psychiatry now dominates the field and its emphasis upon treatment has already begun to revolutionize in-patient psychiatry. It is one of the many things for which we must thank Sigmund Freud, who first introduced an effective, systematic psychotherapy, that psychiatric treatment began to be thought of as applicable to ambulatory, non-committed patients. Ernest Southard was probably the first to put this into practical application in the form of an out-patient department.[1]

Child guidance clinics, mental hygiene clinics, rehabilitation clinics and other euphemistically labelled agencies for out-patient psychiatric treatment have multiplied in the wake of psychoanalytic private-practice out-patient psychiatry, until today the psychiatrist is no longer thought of exclusively as the guardian of committed patients but as the counsellor of patients for whom commitment is unthinkable. The extensions of psychiatry in the direction of "psychosomatic medicine," and of cooperation with the general practice of medicine and surgery, in the direction of industrial psychiatry and personnel work, in the direction of mental hygiene counselling in colleges and high schools and of interpolation with educational projects generally—these and other extensions of psychiatry are all extra-mural functions for which institutional psychiatric training provides an inadequate background. The problem of the psychoneurotic is in every way a more complicated, extensive and difficult one than the problem of the psychotic and in contradistinction to the attitude of the older schools of thought, the psychoneurotic is now a recognized problem for psychiatry. Private psychiatric consultation offices have been opened in most large cities. To all these will soon be added the consultation services of psychiatrists in education, in industry and in personnel work generally.

All this now becomes a hundred times more important when the country is faced with the return of psychiatric disabilities from the Army at the rate of 1000 per day, most of whom, if seen at all by psychiatrists, will be seen as psychiatric out-patients. What it means is not that the hospital residency in psychiatry should be abandoned or that it should cease to be the basic feature in specialty training. It means that if this training is to be brought up to date it must be so organized and directed that the resident learns in the hospital not only what to do for hospitalized patients, but the more difficult question of what to do for and with out-patients. Hospital training can be formulated with this objective; for the most part it has not been. Out-patient diagnosis must be made with a more skillful

[1] See Lawson G. Lowrey, Psychiatry for Children, *Am. J. Psychiatry*, 1013:75-388, 1944, which gives reference to Richard Cabot's *An Appreciation of Elmer E. Southard.*

precision, at greater speed and under greater difficulties than in the case of hospitalized patients. Out-patient treatment programs are different from those for hospital patients and must be offered and carried out in a different way. The management of the relatives of committed patients, difficult as it often is, is certain to be less difficult than the handling of, let us say, the parents of a problem child.

The influence of out-patient psychiatry upon intra-mural psychiatry has thus far been chiefly in the direction of treatment. Most of the better psychiatric hospitals now undertake some systematic psychotherapy with at least some of the resident patients. The specific prescription of occupational therapy, of recreational therapy, of educational therapy, of companionate therapy, is slowly tending to replace mass assignments on the basis of "quiet patients" and "closed ward patients." The great virtue of hospital residency is the opportunity for frequent, relatively prolonged observation and continuous study. If the pressure put upon the resident in large institutions forces him away from the intensive study of the individual toward the problems of mass management, he tends to become an administrator rather than a medical psychologist. We need psychiatric administrators but at the present time we need psychiatric therapists far more and especially those proficient in therapies other than those applicable only in a hospital.

The novice, the young physician fresh from his interneship or from a few years of medical practice, enters his period of psychiatric residency in a state of bewilderment. He is in a strange new world. Attitudes, procedures, terms, symptoms, treatment methods, all seem far away from those which he associates with the practice of medicine. To allow a young doctor in this frame of mind to flounder about, observing this patient and that one, following this staff physician or the other, picking up a few things from fellow residents and a few from cryptic discussions or sharp arguments at staff meetings—this is not good resident training. To be sure, the intelligent physician will absorb something from such an exposure but he will do so with much lost time and waste motion and, sometimes, with considerable emotional disturbance.

I feel that it is important that the psychiatric novitiate be exposed by plan and design to the right doctors, the right atmosphere, the right patients, the right topics of instruction, the right staff instructors. It is important that this exposure be shifted or rotated so that he comes to understand respectively the implications of hospital admission, the techniques of diagnostic study (including the cooperative function of the psychologist) and the nature of case analysis and case presentation; the indications for prescription and application of therapy; the problems of management of relatives, discharge procedure and patient follow-up; the functions of psychiatric nurses, psychiatric social workers, psychiatric occupational therapists, physical therapists, occupational therapists and

recreational therapists. Only after he has gained a familiarity with these fields of psychiatric functioning can he get on to the more difficult problems of psychotherapy, child psychiatry and out-patient management.

In all of this exposure to experience the resident needs guidance. He needs reading prescription, he needs didactic instruction, he needs tutorial counsel, he needs seminar participation. The training of the average resident can no more be left to chance than can the training of the lawyer. In this respect psychiatry differs from some specialties which are more particularly crafts or techniques based on certain established principles which are the same in every case (e.g. asepsis, hemostasis, drainage). In psychiatry there are no such well defined "basic principles."

In our own experience at the Menninger Hospital (and Clinic) we have encountered the difficulties involved in a changing psychiatry. Along with our sister institutions, we began our teaching years ago on the old assumption that intra-mural psychiatry *was* psychiatry—provided an adequate treatment program could be included. We made provision for the didactic instruction of our residents in various fields of hospital psychiatry. We discovered that this was inadequate—that we were obliged to re-orient our teaching with a new emphasis upon the out-patient problems. We discovered, too, that the teaching program necessary for the adequate training of our residents was far more expensive than we had calculated. *Residencies which are essentially only medical assistantships save the hospital money, but they do not train the residents.* To train a resident adequately costs the hospital money, over and above what his services are worth, at least for the first two years. If we want better psychiatrists, we must provide better training but better training costs money and hospitals cannot afford it. Neither, on the other hand, can the average resident afford it.

Another matter about which the American Psychiatric Association should early come to a publicly announced decision is the question of just what a residency in psychiatry should provide for the resident. As stated above there is, at the present time, a wide variation among the numerous approved hospitals. Many of them give no instruction in child psychiatry or in psychiatric theory or in neuropathology or in psychotherapeutic techniques or in adequate record preparation or in psychological testing. In some there are monthly staff conferences, in others daily staff conferences. In some no regular seminars are provided, in others these are held frequently, with outside speakers, staff presentations, resident participation.

It would seem that agreement might be reached among those concerned with psychiatric education in regard to (1) the objectives, (2) the devices, and (3) content of psychiatric training.

The *objectives* might be defined in general as that of equipping medical graduates with a body of knowledge, certain techniques or skills, and the acquisition of a certain spirit or attitude characteristic of psychiatry.

The *devices* serviceable to these ends should include:

a) Certain assigned readings and certain recommended readings, both technical and general.

b) The assignment of selected cases with guidance in their preparation, presentation, management, treatment and discharge.

c) Systematic group conferences with reference to the treatment of specific cases.

d) Individual conferences or control sessions not less frequently than once a week and over a period of not less than 9 months for at least a few cases whose treatment continues that long.

e) Seminars and didactic lectures covering certain problems and fields in psychiatry for which reading is often less effective as a source of instruction.

f) Subjective experiences. All psychoanalysts must be psychoanalyzed; whether those using hypnosis and other techniques should themselves submit to the experience is an unsettled question. Certainly, however, all psychiatrists should have the experience of taking the psychological tests, of formulating an autobiography, and of working, playing and living with psychiatric patients.

As to the *content* of the instruction there would seem to be at least five main fields.

a) *Orientation* which includes an acquaintanceship with the history of psychiatry, with the nature of psychiatrist-nurse relationships, psychiatrist-social worker relationships, psychiatrist-psychologist relationships, etc. The average young resident is at first completely incapable of appreciating the function of the psychiatric nurse, for example, because he thinks of her in terms of the nurse on the surgical or medical ward with whom he has had experience as an interne, and the same applies to other professional relations, not the least important of which is his relation to the non-psychiatrically oriented (outside) physician.

b) *Diagnosis* including personality study techniques, recognition of psychiatric symptoms and syndromes, knowledge of the theory, practice and interpretation of psychological testing, and a grasp of the theory and clinical appearance of "psychosomatic" syndromes.

c) Under *therapy* the resident requires instruction in such general matters as management and attitude therapy, the uses of occupational therapy, recreational therapy, educational therapy, hydrotherapy, etc., and the prescription and checking of these. It is only after he understands these that he can be properly instructed in such special therapies as shock treatment, sodium amytal interviews, drug therapies and the

like, and finally in psychotherapy, the most important and the most technically difficult.

d) *Counselling.* Psychiatrists are daily obliged to confer with general physicians, social agencies, industrial representatives, teachers, relatives and many others who are not patients but who require guidance, advice or information, dispensed in a way likely to be of significant value to them.

e) *Allied fields.* Psychiatry has expanded to embrace not only the thinking, feeling and behavior disorders of adults and children who come to the physician for help but connections with criminology, anthropology, education, formal religion, social welfare and public health. To all these allied fields the resident needs some formal introduction and with them he needs some practical contact.

The author would like to mention here a conviction of his own which may or may not receive general support from his colleagues. It seems to me that psychiatry, above all branches of medicine, requires skill in verbalization. Things must be explained to patients and to patients' relatives and to other physicians. It is amazing how many physicians are inarticulate in private conferences as well as in public appearances. To the end of increasing their skill in verbal communication it would seem desirable to include in the training of every psychiatric resident some instruction in English composition and in public speaking. We are trying this out in our institution. That psychiatrists are so often accused of talking mumbo-jumbo is ascribable to the fact not that psychiatrists know so many technical words and phrases but that they are so inept and unskilled in the use of clear, simple, grammatical English properly composed and clearly enunciated.

This outline leaves unsettled one matter which seems to the author to be of great importance. I refer to the question of just how much instruction of certain types should be officially required as a standard minimum. I omit any expression of personal opinion on this for two reasons. In the first place, I am not sure about it myself but feel that it is something that should be discussed by a group of leaders in psychiatric education. In the second place, it would seem at the present moment to be a somewhat academic problem since the residents now assigned to us for training by the Procurement and Assignment Service are limited to an 18 months' period which is just half enough for basic psychiatric training according to the stipulations of the American Board of Neurology and Psychiatry, Inc., stipulations which represent the consensus among psychiatrists.

The schedule now in use in our own organization, the practical application of the above outline, is contained in the following article by Dr. Worthington, acting medical director of our hospital.

THE INSTRUCTION OF RESIDENTS IN A PSYCHIATRIC HOSPITAL

By ROBERT L. WORTHINGTON, M.D.

In the preceding article, Dr. Karl Menninger has described the status of graduate training in psychiatry, and has indicated some aspects of the tremendous task yet to be done in this sadly neglected field of education. Here will be described briefly the teaching methods used at the Menninger Hospital and Clinic, with the hope that others will publish their residency training programs and teaching methods and that the pooling of these ideas can be a first step toward the setting up of minimum standards for training in psychiatry. The program and teaching methods described here are the ones used at the present time when most residents are allowed only nine to eighteen months of training. We hope soon to re-formulate and publish material on an ideal three-year training program and hope that others too will feel the need to do this. We are keenly aware that we do not now have adequate opportunity for instruction in all fields of neurology and therefore this paper will deal mainly with instruction in psychiatry, because under the Army 9–9–9 program, it has seemed preferable to teach all of the practical clinical psychiatry we could in the nine to eighteen months allowed. Perhaps it should be stated here that formerly we offered a three-year "residency" but found it humiliating and inhibiting to call a physician a "resident" for three years. Hence, we decided to offer one year of "residency" and then a "fellowship" and an "assistantship" for the second and third years respectively. Each appointment is thus for one year only. It is often to the advantage of the "resident" or to that of the hospital for him to go elsewhere after one year.

In the present nine to eighteen months training program the first four to six weeks of the young physician's residency are given over entirely to orientation and indoctrination and he is given no patients. To many active men, anxious to work, this is a trying period, but those sincerely interested in the field will accept the necessity of this "inactivity". Partly in order to allay this anxiety and partly to help the resident establish useful work habits, we have scheduled his time as closely as possible, even during the orientation period. He is immediately given a program covering the whole week, showing times for conferences, lectures, assigned reading, seminars and other activities.

The orientation period is taken up with two main topics: orientation to the organization in which he is to work and orientation to the field of psychiatry. In order to help with the first task, we have set up a "Manual" that covers the history, organization, functions, aims and customs of the

Menninger Foundation and its subsidiaries. It also describes the set-up and rules of each department or service, contains sections on forensic and administrative psychiatry and gives in detail the way in which cases are handled, studied and presented at staff conferences. Finally, there is a considerable section devoted to psychiatric hospital milieu therapy. The residents are given this material for study and later a number of hours are given over to a discussion of its content with the Medical Director.

Parallel with this study, active steps are taken to acquaint the resident with the hospital and clinic facilities, with its personnel and its functioning. Usually a number of two-hour evening lectures by various department heads are arranged in order to clarify and integrate the functions of each department for the resident. Such topics as the psychiatric hospital, psychiatric nursing, occupational, recreational and educational therapy, psychiatric social work, psychological testing, psychotherapy, etc., are covered in a way to give the resident some idea of the new field he is about to enter.

This leads properly to the orientation of the resident to the field of psychiatry. Lectures and seminars are given in considerable number by senior staff members in order to give the new man, but recently immersed in the fascinations of surgery and obstetrics, as much as possible of the psychiatric point of view; that is, the idea of the total personality and its functioning in all spheres of life. Along with this, he is shown the necessity of a broad, mature personality for himself and he is encouraged to become interested in all aspects of human activity, past and present, so that he may better understand his fellow man. To this end his reading, general as well as psychiatric, is guided by a definite reading list: the Bible, the ancient and modern philosophers, the classics of psychological fiction such as the works of Dostoievski, Balzac, Proust, etc., as well as the fundamental works in general psychiatry and neurology. Later he is expected to take an active part in patients' parties, forums, music and art classes, etc. Also seminars conducted by authorities in numerous fields of human endeavor and by our own staff men are held weekly. Much later in his training, the resident is not only encouraged to take part in these but is expected—in normal times at least—to present papers of his own or reviews of current psychiatric or related literature. Toward the end of his orientation period the resident begins to receive more detailed instruction on the admission of new patients, the handling of relatives, psychiatric history taking, the mental and neurological examinations and the preparation of complete case studies for presentation at staff conference. Then from the time he takes his first case, he is kept under constant supervision and instruction in these topics as well as in composition of letters to relatives, writing of progress notes, etc., being given increasing leeway and responsibility, however, as he shows ability to accept it. This instruction is

usually done in individual conferences with the Medical Director or an assistant and although it is very time-consuming, is a necessary and worth while teaching method. Along with this the resident receives instruction usually in groups and often during evening sessions by various senior staff members in the hospital management of patients, in attitude therapy and various related management devices, in the significance of identification, of "transference" and "counter transference" in dealing with patients, the psychiatric uses of occupational, recreational and educational therapy and physiotherapy, in the value of the psychiatric nurse to the resident as well as to the patient, in the dynamic understanding of his patients' personality and illness, etc. Also, he is expected to attend lectures in fundamental psychiatry, two hours a week and in neurology, one hour a week for six months. One hour a week is devoted to lectures by the head of the psychology department on general psychology, the methods of eight psychological tests and their interpretation. The resident is encouraged to discuss the test reports on his individual patients with the psychologist.

The actual hospital management and treatment of patients is covered by a conference of all hospital physicians every morning at 8:30. This conference is also attended by senior members of the nursing and occupational therapy staffs and by psychiatric social workers who report on all hospital patients for the past 24 hours. It is at this conference that the "hospital prescription" agreed upon at staff conference is guided and coordinated. Changes in "privilege" status, minor changes in hospital milieu, etc., are decided upon here with explanations to the resident about what is being done insofar as this is possible. He is encouraged to discuss with the senior staff members all things he does not understand or with which he does not agree, and several hours a week are set aside to discuss problems concerning patients and their relatives.

In the hospital itself, he is instructed at the bedside in such procedures as shock therapy, sodium amytal interviews, tube feeding, restraint of disturbed patients, pneumoencephalography, electroencephalography, and similar procedures, and is given increasing opportunity to perform these procedures under supervision. In supervised visits to the nearby state hospital he learns of the symptoms and care of chronic cases.

After several months of hospital experience and if the resident is felt to be well prepared intellectually and emotionally, he is given an opportunity to work in the outpatient service of the Menninger Clinic as well as in the Topeka Municipal Clinic. Here he no longer has a patient for a two weeks' period of study, testing and observation, with reports from nurses, therapists and others, but must learn "office psychiatry" in which the period of study is much shorter, opportunity for observation is small and he must be able to make a diagnosis quickly as well as plan and carry out treatment. His work on this service is guided by Dr. Karl Menninger at

two outpatient conferences a week and by individual counselling and instruction.

Finally the resident is given instruction in actual psychotherapy. Lectures by Dr. Robert Knight, the head of the department, and others on the principles of psychotherapy are given and a "simple" case is assigned. Each case is "controlled" one hour weekly in individual conferences with a senior staff member, the recorded material being discussed, suggestions given, etc. One hour weekly for a period of eight weeks is devoted to a course on hypnotherapy with supplementary practical instruction in the techniques of hypnosis. For those residents showing the inclination and proper qualifications, training in psychoanalysis (described elsewhere in this issue of the *Bulletin*) is available. After the resident has acquired some understanding of psychoanalysis, he is encouraged to attend psychoanalytic lectures, seminars and papers by outside speakers.

Altogether, then, it is our aim to make the young psychiatrist as well rounded a person as possible, in addition to giving him instruction in the fundamentals of psychiatry and constant guidance in his work with patients. This aim has been hampered considerably by the necessity of teaching our physicians all of the psychiatry possible in a nine to eighteen months' period because of the war. Even after the war, much will remain to be done here and elsewhere in the organization and standardization of psychiatric education for physicians. As so often happens with the medical profession, our various assistants and helpers are away ahead of us in the setting up of educational standards, particularly in the fields of nursing and social work at the present time, and one must wonder why this is so.

For a period of sixteen years, by a system of trial and error, we have been trying to improve our methods of psychiatric training. We are aware of many defects and deficiencies still present in our program but for what it may be worth to those interested in helping us to improve our program or perhaps to modify their own plans in certain respects, we present below an outline of the present plan (as of January, 1945). In the nine to eighteen months' period allowed for residency these days, we have felt that the experience described below in child psychiatry will not be especially useful to men going into the Army and most of them have elected to spend full time in adult psychiatry. It is listed here because it is part of the regular three year program and because we have an occasional resident now who does not come under the Army 9–9–9 program.

SCHEDULE OF RESIDENT TRAINING AT THE MENNINGER CLINIC

Schedule for 1945 (Prepared December 20, 1944)

Faculty: Dr. Karl Menninger, Chairman; Dr. Robert P. Knight, Dr. Robert L. Worthington, Dr. David Rapaport, Dr. Merton Gill, Dr. Margaret Brenman, Dr. William L. Pious, Dr. Mary Leitch, Dr. Ruth Barnard, Dr. Dana S. Crum

I. *Adult Psychiatry:*

A. *Location:* The Menninger Sanitarium, the Menninger Clinic and Topeka Municipal Clinic Services.

B. *Service Chief:* Drs. Robert Worthington and Karl Menninger.

C. *Period:* The entire period of training at the present time is eighteen months, or six quarters, less the time for special assignments. In the pre-war plan each year of residency was divided into "quarters" with more specific place and time assignments. At present the residency is concentrated in the hospital service with opportunities however, to spend time on other services in accordance with the needs of the service and of the resident. In general, residents spend about three-fourths time in the hospital service with one-fourth time for all the other services except outpatient, psychotherapy and child psychiatry. After sufficient basic training, and if aptitude is shown, they may be assigned one-half to three-fourths time in outpatient service with an opportunity for some types of psychotherapy under supervision in the later months of the training period. When residents are assigned part or full time to the outpatient service, they attend outpatient conferences (Tuesdays and Fridays, 2-3 p.m.).

D. *Hours:* Hospital staff conference is held at 8:30 a.m. daily. Hospital duties continue through 5 p.m. All physicians on this service are assigned to night and week-end calls in rotation. The physician on call on week-ends spends the hours from 9 a.m. to 5 p.m. on the hospital grounds and may have to spend the night there.

E. *Clinical duties:*

1. Admission of new patients to the hospital.
2. Complete personality study of assigned patients including psychiatric history taking, physical and neurological examinations, direction of clinical and psychological laboratory examinations, etc., with the assistance of medical and neurological consultants, psychologists, social workers, etc.
3. Preparation of complete case study abstracts and presentation of them at staff conferences.
4. Management of the patient in the hospital and responsibility for carrying out the staff treatment recommendations under the supervision of the medical director. Includes short daily interviews with all assigned patients.
5. Recording weekly progress notes on assigned patients and corresponding with relatives.
6. Administering tube feedings, intravenous treatments, anti-syphilitic treatments, and all general medical care of assigned patients.
7. Administration, under supervision, of various types of shock treatment, including the use of curare.
8. Supervision of restraint of patients when necessary.
9. In conjunction with psychiatric social workers, making arrangements for the patient returning home, or for boarding home placement and for the schooling or job placement of certain patients.
10. Participation in general seminars held one night weekly ten months of the year.
11. Making similar but shorter studies of outpatients in the Outpatient Department of the Menninger Clinic and in the Psychiatric Division of the Topeka Municipal Clinic.

12. Attendance at certain patient social and recreational functions in the evening as assigned.
13. Review of neuropsychiatric literature for the Library Review.

F. *Subjects for study and instruction, in approximate order of introduction:*
1. Hospital routine duties; patient management and treatment.
2. Techniques of psychiatric examination.
3. Construction of records.
4. Progress notes.
5. Interviewing relatives.
6. The prescription of hospital milieu therapy, including therapeutic aims, management devices, attitudes, etc.
7. Psychiatric social work.
8. Psychotherapy.
9. Psychiatric hospital organization and administration.
10. Visits to Topeka State Hospital to study custodial care and management problems.
11. Management of outpatients, including psychotherapy.

II. *Child Psychiatry:*
A. *Location:* Southard School
B. *Service Chief:* Dr. Mary Leitch.
C. *Period:* One quarter for each resident.
D. *Hours at School:* 11:30 a.m. to 5 p.m. daily (except City Clinic hours Wednesday afternoon and staff conferences).
E. *Clinical duties:*
1. Work-up of new cases (children—in- and outpatient services).
2. Treatment and follow-up on Outpatient Department children's cases.
3. Weekly progress notes on children at the School.
4. Attendance at School conferences and seminars.
5. Assistance to Juvenile Court consultant.

F. *Subjects for study and instruction:*
1. The Southard School Routine. (See School Manual)
2. Neuropsychiatric history taking and examination in children.
3. Principles of parent-child-adult relationships.
4. Principles of child psychiatry.
5. Principles of child analysis.

III. *Psychotherapy:*
A. *Location:* Clinic, Sanitarium and Southard School.
B. *Service Chief:* Dr. Robert Knight.
C. *Period:* Third and fourth quarters.
D. *Hours:* One-fourth to one-half time, by arrangement.
E. *Clinical duties:* Psychotherapy in assigned cases.
F. *Subjects for study instruction:*
1. Psychotherapy techniques (including hypnotherapy).
2. Psychoanalytic technique, including supervised analyses for residents who are psychoanalytic candidates.
3. The general therapy principles involved in cases who are in treatment or about to be.
4. Psychodynamics of cases to be presented at staff conferences.

IV. *Psychology:*
A. *Location:* The Menninger Foundation Research Building
B. *Service Chief:* Dr. David Rapaport

C. *Period:* All four quarters
D. *Hours:* One hour a week; Saturday at 1 p.m.
E. *Clinical duties:* None
F. *Conferences:* Individual discussion of the test material of each case worked up by the resident; seminars on the use of eight or more psychological tests.

V. *Neurology:*
A. *Location:* Clinic, Sanitarium, City Clinic, local hospitals and the Topeka State Hospital.
B. *Service Chief:* Dr. Ruth Barnard.
C. *Period:* First and second quarters.
D. *Hours:* By arrangement.
E. *Clinical duties:*
1. History taking and neurological examinations in all neurological cases; brief form of psychiatric examination.
2. Assistance in pneumo- and electroencephalography.
3. Lumbar punctures and other neurological techniques.
4. General assistance to the chief of the neurological service in various procedures
5. Reports on current neurological literature at seminars.
F. *Subjects for study and instruction:*
1. Neurological history taking.
2. Neurological examination techniques, including use of various types of apparatus.
3. Neuroanatomy, neuropathology, general neurology, etc.

VI. *Research Projects:*
A. *Location:* In appropriate facility.
B. *Service Chief:* Dr. David Rapaport
C. *Period:* All four quarters
D. *Hours:* Not more than one hour a day of regular working time can be allowed the resident for research projects. Most major projects will require some of the resident's free time in addition.
E. *Clinical duties:* Depend upon project.
F. *Subjects for study:* To be suggested by the chief-of-service.

VII. *Informal Counselling and Study:*
The service chiefs will act as counsellors for the residents and will confer with them one hour a week, and, in addition, will make all work assignments. Study assignment will be left to the discretion of the resident. Most study and reading will have to be done outside of the hours assigned for clinical duties. (See recommended reading list for residents posted in the library.)

VIII. *Seminars and Lectures:*
Regularly scheduled seminars and lectures by staff members on military psychiatry, psychiatry for nurses, abnormal psychology and criminology for college students, mental hygiene, and psychiatry for social workers, are also available to the residents. Included in this are two hours of lectures a week on general psychiatry for six months and one hour a week on neurology for a similar period. Many of the psychoanalytic seminars and lectures are open to the residents, even though they may not be candidates in psychoanalysis.

IX. *Psychoanalytic Training*—See paper by Dr. Robert Knight in this issue.

TRAINING IN PSYCHOTHERAPY AND PSYCHOANALYSIS

By ROBERT P. KNIGHT, M.D.

For thousands of years people have tried by verbal communication to relieve the emotional distress of others. Formal attempts to do so have long been a function of priests, rabbis and ministers for whom the spiritual comforting of their followers was regarded as a professional function. But the word psychotherapy means literally "treatment"—treatment by psychological modalities—and the treatment of a sufferer, the treatment of one who considered himself not grief-stricken or soul-burdened but ill, has long been considered a function of the physician. The fact that a patient comes to a physician for relief is the basic situation under which psychotherapy along with all other therapies can be administered in a definitive way.

Although Hippocrates, the father of medicine, employed psychotherapy to treat successfully the mental illness of King Perdicas of Macedonia,[1] and many physicians through the centuries have intuitively used psychotherapeutic techniques, psychotherapy has, until recently, remained a kind of formless art practiced by good, bad, and indifferent exponents who have included the clergy, psychologists, physicians, psychiatrists, educational counselors, social service workers, "good friends," Christian Science practitioners, and many charlatans. The value of the psychotherapy done has depended not on the vocation or qualifications of the therapist, but on his individual earnestness, sincerity, intuitiveness, and capacity for inspiring or otherwise influencing the person in distress. Much of it has undoubtedly been ineffectual or actually deleterious.

Only in the last few decades has there developed a *science* of psychotherapy. Rational, scientific psychotherapy had to wait for the emergence of scientific dynamic psychology and psychopathology, just as medical and surgical therapies had to be based on scientific physiology and pathology. Also, the special brand of dualism which regarded man's body (soma) as the domain of medicine, and his mind (psyche) as the domain of religion or lay psychology had to be replaced with unitary, mind-body, psychophysical concepts in keeping with the observed scientific facts. "Psychobiology" and "psychosomatic medicine" are attempts to break up this unsound dualism and arrive at a scientific diagnostic appraisal and scientific total therapy of the individual patient as a unit.

Such a progressive trend in medicine involves not only the conceptual unification of psychological and physical medicine but also has certain

[1] Brill, A. A.: Anticipations and Corroborations of the Freudian Concepts from Non-Analytic Sources. *Am. J. Psychiat.* 92:1127–1135, March 1936.

practical implications for the relationship of the specialty of psychiatry to the other medical specialties and to general medicine. It means, on the one hand, that psychiatry is growing out of its restricted area of caring for the mentally ill into a broad field which includes treatment of the mentally ill, diagnostic and therapeutic participation in the psychological aspects of the whole gamut of human disease and distress—physical, psychological, emotional, sociological—and active contributions to prophylaxis in mental and physical hygiene. Infant care, child rearing, marriage counseling, better teaching and disciplinary methods in education, enlightened handling of juvenile delinquents and adult criminals, better methods in industrial psychology and personnel work—these are a few of the areas in which the scope of psychiatry is being enlarged. Psychiatry is by no means ready to give the final answers in all these fields, but they represent the directions in which its frontiers are extending.

On the other hand, this progressive trend in medicine means that medical men will have to become increasingly better oriented and skillful in the use of psychological knowledge and techniques. They will not only have to be aware of psychogenic and collateral psychological factors in the illness of patients who consult them, but will have to be able to *treat* these aspects, along with the other phases of the illness. Such treatment is psychotherapy and in the great majority of medical schools at present no provision is made to give instruction in the techniques of psychotherapy. Only postgraduate instruction in psychiatry makes any provisions for such training, and, unfortunately, only a few of the postgraduate institutes providing instruction in psychiatry offer training in all types and degrees of minor and major psychotherapy.

Specifically, psychotherapy means the attempt, by verbal intercommunication between patient and therapist, to influence favorably the patient's mental health—to relieve his anxiety, to bring about more constructive uses of his energies, to improve the quality of his relationships with others, to promote the integration of conflicting feelings and tendencies in his personality, to increase his powers of adaptation to his environment and its stresses, to cause him to know and understand himself better. In order for a therapist to achieve these aims with a patient he must understand what constitutes emotional health, what internal and external (cultural, environmental) conflicts threaten it, and what any particular patient is reacting to and expressing in symptom formation, maladaptive behavior, or attacks of anxiety. The therapist must be able to convey usable insight to the patient, and he cannot do this unless he himself has insight. Without insight, the therapist is blind and is leading the blind. Yet much of what has passed for psychotherapy (under various names) is just such a blind attempt to reassure, exhort, persuade, intimidate, ridicule, or

otherwise to influence the patient to "forget his troubles" without any but the haziest awareness of what is really disturbing him.

There are all degrees of severity of emotional disturbances from the transient anxieties, symptoms and depressed feelings of the fairly normal person reacting to stress (physical illness, injury, loss of a loved person, loss of a job, financial loss, betrayal by a friend, witnessing a terrible accident, etc.) through the acute and chronic psychoneuroses (fixed maladaptive patterns of behavior and feeling with anxiety and some disability) to the psychoses (complete breakdown states with full disability and severely abnormal thoughts, beliefs and feelings). The place of the general medical man in relation to this series is thoroughly and excellently discussed in a sound book by Dr. Maurice Levine, *Psychotherapy in Medical Practice*.[2] A thorough study of this book by a physician with a feeling for emotional distress would equip him to handle much "minor" psychotherapy in his practice, and would show him where his limitations are. Such a book should be the text for a required course for all undergraduate medical students.

For diagnosis and treatment of the more severe psychiatric conditions—character disorders, addiction, perversions, phobias, hysterias and compulsion neuroses—as well as for the psychoses—full training in psychiatry and psychotherapeutic techniques is essential. Psychiatrists who attempt to do more than the administration and giving of injections, sedatives and shock treatments must carry on some kind of psychotherapy with their inpatients, and, of course, psychotherapy is the main kind of treatment for outpatients. What kind of psychotherapy is suitable and how it should be conducted and for what period of time—these are matters in which the psychiatrist should be thoroughly trained. Psychoanalysts devote their entire time to intensive psychotherapy of the psychoanalytic type. Their attempt is more thoroughgoing and more intensive as well as more extensive and prolonged, and might be compared to major surgery consisting of a series of operations over a period of a year or two. They hope to achieve not merely relief of symptoms but reorganization of the personality through uncovering of unconscious, repressed memories and impulses, with redirection and reintegration of the drives and energies thus released. Their training is the longest and the most specialized, but it should equip them to do not only psychoanalytic therapy, but any kind of effective psychotherapy suitable for the case at hand.

In eighteen months (the maximum time allowed under the war program for a psychiatric residency) the psychiatric resident cannot learn much about the actual techniques and problems of psychotherapy in addition

[2] Levine, Maurice: *Psychotherapy in Medical Practice*, New York, Macmillan Co., 1942.

to all the basic training in psychiatry that he must absorb. However, he can learn certain general principles on which psychotherapy must be based—the structure of the personality, the nature of unconscious motivation and of emotional conflict, the mechanisms of defense against anxiety, and other elements of dynamic psychology—and he can be taught the fundamental factors in the patient-doctor relationship during psychotherapy. We attempt to carry out this instruction through a course of lectures in dynamic psychology, through intensive case studies and discussions of dynamics and psychotherapeutic approaches, through reporting in detail of the psychotherapy of past cases by an experienced staff member, and through controlled attempts by the resident to do psychotherapy on selected cases during the later months of his training. Such "controlling" consists of supervision by an experienced staff member in which the resident reports exactly what has been said and done by himself and by the patient while the supervisor points out errors, shows what has been overlooked, explains the meaning of the patient's behavior and verbal productions, and makes suggestions as to future handling. Through such experience the resident learns the meaning of "rapport," of defensive measures by the patient, and of the resident's own "blind spots," over-caution or too great temerity, and thus gradually learns how to conduct a series of effective psychotherapeutic interviews with a patient.

For intensive training in psychotherapy and in its most highly developed technique, psychoanalysis, a complete course of training in a psychoanalytic institute is necessary. There are six training institutes in psychoanalysis officially recognized by the American Psychoanalytic Association—the Boston Psychoanalytic Institute, the Chicago Institute for Psychoanalysis, the New York Psychoanalytic Institute, the Philadelphia Psychoanalytic Institute, the Topeka Institute for Psychoanalysis and the Washington-Baltimore Psychoanalytic Institute. Training activities are also carried on in Detroit, as a branch of the Chicago Institute, and in San Francisco and Los Angeles as affiliates of the Topeka Institute. Recently the first full training program in psychoanalysis to be set up as a postgraduate course in conjunction with a medical school was established at Columbia University, under the direction of a group of training analysts of the New York Psychoanalytic Society. All of these institutes have the same general admission requirements, minimum standards, and content of courses. A composite of these training programs follows:

A. *Admission Requirements*

I. *Scientific Training*

a. M.D. degree from a class A medical school accredited by the American Medical Association, or from a foreign medical school of equivalent standing.

b. A general internship for at least one year in a hospital approved by the American Medical Association, or in a foreign hospital of equivalent standing.

c. Completion of at least one year of full-time work with inpatients in a psychiatric hospital approved for residency by the American Psychiatric Association and the American Medical Association, or in a foreign hospital of equivalent standing. (Two years of psychiatric residency are required by several institutes, although the psychoanalytic training may be started after one year of residency. Three years of psychiatric residency are required for specialty certification in psychiatry.)

II. *Personal Suitability.* The applicant must satisfy the Educational Committee as to the maturity of his personality, the integrity of his character, and his aptitude for psychological work, and also must be free from disabling neurotic disorders.

III. *Pledge of Good Faith.* Before enrollment the applicant must pledge himself in writing neither to conduct psychoanalytic treatments nor to represent himself as a practitioner of psychoanalysis until he is authorized to do so by the Educational Committee.

B. *Required Training*

I. *Didactic or Preparatory Analysis.* Each candidate must undergo a preparatory analysis with a qualified training analyst, consisting of not less than three hundred hours. The primary purpose of this personal analysis is for the candidate to gain deep insight into his own personality and learn the facts of unconscious conflict, repression, and psychodynamic mechanisms through personal experience. Also, he should become freed from personal bias and blind spots which might interfere with his work with patients, and he has the opportunity to learn psychoanalytic technique as it is carried out in his own case.

II. *Theoretical Courses.* Theoretical instruction begins only when the candidate is so advised by his analyzing instructor. The following course titles and number of hours vary among different institutes. The outline given represents an attempt at a composite program.

a. Basic Required Courses

1. General Introduction to Psychoanalysis—10 hours
2. Seminar on Freud's Writings and Psychoanalytic Literature—36 hours
3. Scientific Methodology of Psychoanalysis—12 hours
4. Mechanisms of the Individual Neuroses—10 hours
5. Interpretation of Dreams—32 hours
6. Psychoanalytic Technique—18 hours
7. Psychoanalytic Psychiatry—36 hours
8. Ego Psychology—Anxiety and Defense Mechanisms—12 hours
9. Continuous Case Seminar (Group Control)—50 hours

b. Elective Courses

1. Application of Psychoanalysis to Related Fields—Medicine, Social Work, Sociology, Anthropology, Education, Child Psychiatry
2. Child Analysis, Theory and Technique
3. Psychological Testing, including the Rorschach Test
4. Selected Topics—the Perversions, Impotence and Frigidity, Modified Techniques for Psychoses, Special Problems of Female Psychology
5. Hypnosis and Hypnotherapy
6. Selected Topics in Psychosomatic Medicine

III. *Supervised Clinical Work.* Treatment of at least two patients (more if possible) for one year each under the weekly supervision of a training analyst, with at least one case being carried to completion under supervision.

C. *Oral Examination* on problems of theory and technique, conducted by at least two training analysts.

D. *Thesis.* The candidate must present to the society a detailed case report of a patient treated by himself, developing the theoretical and clinical aspects of the case with reference to pertinent literature.

The above training program ordinarily requires about three years of postgraduate work (four if the first year of required psychiatric residency is included) and may be combined with the requirement of three years of psychiatric residency necessary for certification in psychiatry. Associate membership in a local psychoanalytic society is conferred upon the candidate upon the successful completion of the training program, including the oral examination and thesis. After two years of associate membership, the candidate is eligible for active membership in the local society, which automatically confers upon him active membership in the American Psychoanalytic Association, the official psychoanalytic professional organization in this country. After five years as an active member, during which he has demonstrated clinical competence and has made contributions to the psychoanalytic literature, he may be designated a Training Analyst by the Educational Committee of the local society if he has shown distinctive teaching ability.

The place of psychoanalysis in psychotherapy is secure but it is obvious that only a minimal number of persons can be treated by the lengthy process of psychoanalysis. Only a few need to be. Constant research is going on to discover and develop shorter methods so that more patients can be treated successfully, but all shorter methods will derive to some extent from the contributions of psychoanalysis to psychotherapy. Most physicians do not need to be concerned with the psychotherapeutic techniques suitable for severe and chronic cases. Every practicing physician, however, needs to know how to do "minor" psychotherapy and how to judge what cases need more extensive treatment. This minimal knowledge of usable psychiatry and psychotherapy should be learned in every medical school course.

TRAINING IN CHILD PSYCHIATRY

By MARY LEITCH, M.D.

It is usually desirable that training of any type should be closely related to the future functions of the trainee. This becomes essential in war-time. In the field of psychiatry, greatly accelerated programs of study must now be offered to many young physicians with a view to their entering the armed forces and coping efficiently with the wide variety of emotional problems encountered in men and women under the special stress of war conditions. It cannot be conceived that, in these brief programs, much stress can either practically or with profit, be placed on training in child psychiatry. Hence, the reflections below are intended to apply only to the post-war era and to the present training of a few young psychiatrists who will not be inducted into the army, and so can pursue a more leisurely course of study.

Many leading psychiatrists believe that every young psychiatrist should have a certain amount of training with children. What are the objectives of such a program? Certainly the aim is not to force child psychiatry on the trainee and, willy-nilly, to make him proficient in the practice of it. Rather it is to enable him the better to give sound advice to his adult patients who need help in the management of their children, to learn about normal personality-development, to see the beginnings of adult problems in childhood and to gain familiarity with techniques which can be useful to him, even though he chooses the practice of adult psychiatry. Assuming that the training program is an attractive sample of child psychiatry, he is given an opportunity to see what this field has to offer and to determine whether it holds for him an interest so profound that he wants to devote his energies to it in the future. This seems particularly important because child psychiatrists are so badly needed and so sadly few in number.

At least one year of clinical and didactic training in adult psychiatry is to be considered prerequisite to the training experience with children. This is for the purpose of providing the trainee with the necessary general psychiatric orientation and a suitable point of reference. Some familiarity with mental illnesses in adults will facilitate awareness of the possible outcome of children's maladjustments if not treated. Usually it is more difficult for the beginner to place himself on the level of the child than on the level of the adult and dealings with the child demand a greater degree of ease and skill in the situation than do dealings with adults. Needless to say, previous experience with children, professional or otherwise, is helpful to the trainee although it is not essential.

Where can suitable training in child psychiatry be had? That in itself

is a big problem. Ideally the trainee should gain experience with children in all phases of their development, with all types of illness and from the various social classes. He should see and observe continuously those that are so sick that they have to be removed from their homes and treated in special schools or hospitals as well as those whose maladjustment is mild enough that they can be treated in their own homes or in boarding homes. He should have an opportunity for contacts with parents, psychologists, social workers, teachers and officers in the community. Above all, he should have close by him a competent child psychiatrist to guide him in his work. Very few training centers offer such broad facilities. At the present time unless the trainee can go to a well equipped center, recourse must be had to whatever opportunities happen to be available in the community in which he lives. Valuable experience with children can be gained in psychiatric residential schools, in the children's wards which are to be found in a small number of good psychiatric hospitals, in the out-patient services of psychiatric hospitals and clinics, in child-guidance clinics and occasionally in the reliable nursery school and summer camp for maladjusted children. The writer thinks that particularly much is to be gained by actually living with sick children and attempting to put into practice what one tends glibly to preach. Here is a first rate opportunity to have one's patience tried to the limit, to find out how difficult it is to keep the restless inattentive child happily occupied and to learn what one says and does when text-book suggestions suddenly prove to be hopelessly vague and inadequate. Children are seen to do and heard to say things which they never do or say during a psychiatric interview. They are observed while experiencing an emotion at the moment it occurs in all its intensity. One appreciates more how the child suffers and at the same time secures a better understanding of exactly what the parents of the problem child are up against twenty four hours a day.

The length of time devoted to the training should depend on the reactions of the individual trainee whenever possible. All work with sick children involves a serious emotional experience for everyone concerned. If the trainee is unhappy in his work with children, the program may well be limited to a three months period. On the other hand, if the situation is to his liking, he can profitably spend nine to twelve months in it, even though he has no intention of continuing in child psychiatry. Sometimes the training may be carried concurrently with continued training in adult psychiatry. However, this is never advisable if only a short period of time is available for the program.

The details of the training program must, by necessity, vary considerably with the individual trainee, the length of time available for it and the clinical facilities. As indicated before, an experienced child psychiatrist

should always be responsible for close supervision of the trainee's work. Whether or not this should ever include the trainee's observing interviews or having his interviews observed is problematic.

One training program, that planned by the Southard School (a private psychiatric residential school in conjunction with which boarding homes are used), is mentioned below to serve as an illustration. It is not intended as a model. In explanation it should be said that in addition to study within the School, the program offers experience with children in the outpatient department of the Menninger Clinic and in a municipal clinic for indigent persons.

A. Period of training: 9 months.
B. Subjects for study and instruction:
   1. General orientation (explanation of the attitudes, purposes etc. of children's work and of the School and out-patient services; discussion of trainee's responsibilities; reading and discussion of cases' records).
   2. Neuropsychiatric history taking in children.
   3. Psychiatric examination of children (including Levy's psychiatric-physical).
   4. Principles of parent-child-adult relationships.
   5. Detailed principles of child psychiatry.
   6. General principles of psychotherapy in children.
   7. Psychological testing of children.
   8. Placement of emotionally ill children in specially selected boarding homes and guidance of foster parents.
   9. Recreational, occupational and educational therapy in children.
   10. Construction of case records.
   11. Writing of progress notes.
   12. Prescribed reading.
C. Clinical duties.
   1. Complete work-up of selected School and out-patient cases (history taking, psychiatric, physical and neurological examinations, psychiatric interviews).
   2. Preparation of case abstracts for presentation at staff meetings.
   3. Bi-monthly progress notes about children at the School.
   4. Examination and treatment of children in neuropsychiatric division of municipal free clinic (2 hours a week).
   5. Daily counselling with selected in-patients.
   6. Assignment to recreational therapy and/or educational therapy (not more than one hour daily).
   7. Review of current child psychiatry literature for seminars.

GRADUATE TRAINING IN PSYCHOSOMATIC MEDICINE

By GEORGE E. DANIELS, M.D.*

Psychosomatic is a term so frequently on doctors' lips, not only those of psychiatrists but of general medical men, that it threatens to take on the qualities of a slogan, and to suffer the same fate that slogans do, generating enthusiasm while it lasts but burning out from its very intensity. This need not happen if the trend in medicine which it represents is allowed natural and sound growth and a chance to become incorporated into the main stream of medicine. The best chance of assuring this is sound training of those who will do investigation and practice in this field.

The term *psychosomatic* is frequently under attack, and unquestionably has certain limitations which will not be gone into here. It is useful, however, to point up a contemporary movement in medicine which gives promise of revolutionary developments. *The psychosomatic point of view is the proportionate consideration of physical and psychic factors in disease.* This has been the ideal of medical practice through the ages, but it is only within the last fifty years that we have had means to make this scientifically realizable. Revolutionary changes in psychological medicine have been chiefly responsible, but comparable developments in biological medicine are complementary. The present confluence of these two streams gives the real strength to the psychosomatic evolution.

One large stream springs from modern physiological investigation stimulated by clinical medicine but founded on laboratory science and animal experimentation. This has furnished the genuine biological basis essential to a sound psychosomatic medicine. Cannon and his classical experiments on the physiology of emotion and Pavlov with the conditioned reflex represent one part of this. Another tributary came through the rescue of endocrinology from the area of animism and quackery by the laboratory scientists, chief among them the anatomists, who had reached a dead end in the study of morphology and utilized embryology as the vehicle for a new birth. Brilliant discoveries have resulted in sex determination and modification, the growing knowledge of interrelation of glands of internal secretion with the pituitary as the master gland, and synthetic production of the various hormones. The clinical applications have been far reaching in diabetes, undescended testicle and various other replacement therapies. The work of Banting and Best, Ascheim and Zondek, Butenandt, Doisy, Smith and Engle, and Houssay are examples. Of course essential contributions have been made by clinical medicine, which has given the whole development practical application.

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Various cooperative investigations between physiologist and laboratory endocrinologist have led to rapid fusion of these elements. Bard, a physiologist, utilized hormonal discoveries to study sexual physiology. Gantt and Liddell have refined Pavlov's work in experimental neuroses. Beach, a biologist and animal experimenter, has combined biological research in endocrinology with study of animal behavior.

The other great stream contributing to psychosomatic medicine is psychoanalysis, without which psychosomatic medicine as it is at present developing could not have emerged. Psychoanalysis has provided a method of continued observation of the more primitive elementary mentation through understanding of dreams and symbols and the concept of the unconscious. It opened up the whole infantile background, decisive in personality organization, and important in the understanding of disease in which reversion or regression to infantile behavior is a factor. Furthermore, psychoanalysis led to a scientific understanding of the curative factors in the relationship between physician and patient, the so-called *transference* essential to any well directed psychotherapy.

These two broad streams, both outgrowths of medicine, but originally widely apart, are in the process of integration. Both are dynamic and are going the same way, giving promise of the development of a real human biology. It is this combination which together has promise of establishing a real psychosomatic medicine—internal medicine with a healthy development of knowledge of the emotional factors concerned in physical disease.

Post-graduate training in psychosomatic medicine, as referred to in this communication, is considered a part of a thorough experience in psychiatry and should be integrated with it. It does not attempt to deal with education of the general medical man or medical student in the psychosomatic viewpoint, which is another though exceedingly important problem. Training, to be complete, should embrace training in psychoanalysis, including personal analysis and the other accepted requirements dealt with elsewhere in the symposium. To give a frame of reference, the work outlined will be considered in terms of a three-year training after at least a year's general interneship, such as has been planned for the new Psychoanalytic and Psychosomatic Clinic for Training and Research in the Department of Psychiatry at Columbia University. There the personal analysis is considered a pre-requisite.

The distribution of time in the three-year post-graduate training would depend on the facilities of the center as well as the aims of the student. If, for example, qualification for the American Board of Neurology and Psychiatry is essential, additional training in neurology would have to be included. Although clinical neurology would be useful, a considerable amount is not essential for psychosomatic medicine.

The first two years would be spent in resident psychiatric work in mental hospital in-patient and out-patient departments with access to general medical and surgical services for special training in psychosomatic medicine.

The work in general psychiatry would be supplemented and made meaningful by lectures giving a general psychodynamic orientation along with other exercises related to specific training in psychoanalysis. Included would be lectures and demonstrations on the psychoneuroses and psychoses, also from the psychodynamic point of view. Although knowledge of the psychoneuroses is of particular importance for psychosomatic medicine, a good working acquaintance with the psychoses is essential, as many of the reactions prove to be psychoses masked by a physical facade, and similar personality dynamics are encountered.

In the second year, lectures and clinical conferences on the more definitely biological and psychosomatic subjects would begin. Elementary knowledge of genetics and sex differentiation, with light that this may throw on constitutional or hereditary disease tendencies, is important grounding. Review of physiology, particularly of the autonomic nervous system, coordinated with a systematic study of the endocrine glands, is not only basic for understanding of the machinery through which emotions are expressed, but for grasping psychosomatic conditions such as diabetes, hyperinsulinism, and hyperthyroidism.

For especially gifted students who have the necessary qualifications, the course can be planned with an original problem in mind on which they would write a thesis. This should be chosen fairly early, so that preparation in various basic sciences such as biochemistry, physiology, and animal experimentation which might be essential could be covered in addition to the general psychoanalytic and psychosomatic courses.

As indicated, the post-graduate course which is being outlined is conceived as an integrated three year training in psychiatry, psychoanalysis, and medicine. The question comes up of post-graduate training in psychosomatic medicine in which the student has not undergone a personal analysis and has not had supervised experience in its practice. Such less extensive training is undoubtedly useful; the same things holds, however, for practice of psychosomatic medicine as for psychotherapy. Treatment varies in depth and thoroughness with the training of the operator. The whole course in psychosomatic medicine would have to be worked out on a more superficial level with more modest aims for therapy and psychological investigation. The psychodynamic approach should be used in lectures and conferences, but in assimilative amounts, and partiuclar emphasis should be placed on discouraging the undertaking of treatment relationships which would get out of hand. Without this restraint, the

glamour of a new development with a scattering of psychodynamic concepts can be dangerous both to patients and the reputation of sound psychosomatic practice. The details of such an extended post-graduate training have never been worked out and remain at the experimental stage. The usefulness of carefully modified courses in psychodynamics and psychosomatic medicine has been demonstrated in short courses worked out for army personnel.

To go back to the more basic course, in the second half of the second year, after considerable theoretical foundation and general experience in the psychiatric clinic and hospital, the student is ready to begin work in psychosomatic medicine proper and to commence supervised treatment in a psychosomatic clinic to which such cases can be referred. These would consist of medical and surgical conditions in which the emotional component has been established as important; peptic ulcer, spastic and ulcerative colitis, bronchial asthma, diabetes, essential hypertension, coronary disease, and arthritis, to mention but a few. Psychotherapy, group therapy, and special techniques such as hypnotherapy and narcosynthesis would be taught and utilized where indicated. Emphasis would be placed on intensive psychotherapy short of analysis. The use of specially trained social workers as an adjunct to psychotherapy would be important in clinic experience.

Accompanying six months practical handling of cases in the clinic would be a series of lectures and demonstrations on these medical and surgical problems. Experience is gradually evolving the outlines of typical personalities and conflict situations. For these, contemporary literature should be drawn on freely. Such exercises, however, should be pointed toward clinical application with access to general hospital patient material. The collaboration of members of the clinical and laboratory staffs should be obtained to supplement the psychiatrist's lectures, furnishing pertinent up-to-date information specially selected to the needs of the student and preventing a one-sided approach.

In the last year, the student, if he had been receiving psychoanalytic training, would be ready to undertake analyses of patients under supervision, some of whom would be selected psychosomatic conditions from the general hospital or clinic. He would also presumably continue his work in brief psychotherapy. The student would have finished his residency in psychiatry and if he were doing a piece of research in psychosomatic medicine his main focus would be on this during the third year.

Somewhere in post-graduate training in psychosomatic medicine the use of psychiatric residencies in the general hospital needs consideration. These, depending upon the hospital facilities, could be taken in branches like surgery, gynecology and obstetrics, pediatrics, or any other branch

in which the student's interest lay. Experience has shown in such medical-psychiatric residencies already in operation that analytic training is an important preparation. For the full course outlined in this communication there would not be sufficient time for a year's residency until after graduation unless, due to prior experience, the student had already had his psychiatric in-patient work required during the first two years and had also had other essential training. Whether in a three year post-graduate course without analytic training but psychodynamically oriented such residencies would be practical as the program for the third year would still have to be determined.

Looking forward to the amalgamation taking place between psychological and general medicine, we can get a further cue to the trends that psychosomatic training should take. For example, there is the criticism often made by general medicine that psychiatrists have invaded the field of medicine without giving sufficient weight to the physical facts involved, namely that it is mostly psyche with little soma. This is largely due to the newness of the field and the fact that the psychoanalytically trained psychiatrist has been largely responsible for opening it up because he possessed the necessary instruments of investigation. With the constant interchange of experience, the psychiatrist and analyst will have time to go more thoroughly into the physical aspects. This is being constantly brought about by the medical cases seeking the psychiatrist and being referred for his help.

Parallel to this, the education of medical students and younger medical men in psychosomatic concepts is closing the gap of understanding from the other end. As time goes on it is to be hoped that undergraduate work in psychiatry can be more generally psychodynamically oriented, following the lead of a few schools in which this is already being done. This will make it increasingly possible for the undergraduate student to grasp the implications of the psychosomatic concepts. The working of post-graduate students in psychiatry in medical clinics also furthers this diffusion of knowledge. It is of greatest importance for the student of psychosomatic medicine to be able to speak a language understandable to the general man.

The end result must be a re-writing of medicine with the addition of the psychodynamics in the appropriate places. Some steps in this direction have appeared in the 14th and 15th editions of Christian's *Osler's Principles and Practice of Medicine* which now contains an opening chapter on psychosomatic medicine and places the neuroses at the beginning, following this introduction, as an indicator of the importance of these reactions in general medical conditions. This however stops at the doorstep and does not enter the main building. English and Weiss' *Psychosomatic Medicine* and Dunbar's *Psychosomatic Diagnosis* are ventures primarily

from the standpoint of medical psychology. Portis' *Diseases of the Digestive System*, particularly the second edition, is a good start for a single organ system.

With this coming together of internal medicine and psychiatry and psychoanalysis, the whole transference relationship operating when medication or surgical interference is employed can be studied first hand. Increasing numbers of doctors trained in other specialties will be coming for thorough psychosomatic and psychoanalytic training and will practice psychotherapy in their original fields with all the advantages of a thorough psychological orientation. The psychiatrist also who goes into psychosomatic medicine should more and more continue his original contacts and medical techniqes and supplement them with his psychological training. This should lead in many cases to elimination of the need for two or more physicians in treatment of a single case—a complex therapeutic relationship which sometimes confuses the patient and enables him to play one physician against the other. If there were on each such case a single physician capable of managing both the somatic and psychological aspects of the patient's illness therapeutic results might be accomplished which are at present unobtainable.

In due course of time, the amalgamation sufficiently complete and taken for granted, we may no longer need the term *psychosomatic*. It will have become a part of Medicine of the future.

REPORT OF COMMITTEE ON PSYCHIATRY IN MEDICAL EDUCATION TO THE COUNCIL OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Your committee on psychiatry in medical education recommends that definitive planning regarding graduate and post-graduate psychiatric education be formulated now in anticipation of the needs of partially-trained psychiatrists now in the Service as well as the post-war needs of other medical officers who are anxious to receive training or orientation in this field.

For these purposes, the following general recommendations are made:

1. *Post-War Graduate Training in Psychiatry:* Adequate training should continue, centering upon resident responsibilities and the individual care of patients. It is hoped that institutions offering such training will be able *to increase the number of resident positions through access to the clinical material in nearby hospitals and clinics.* This type of training should include a considerable emphasis on the psychoneuroses as well as on child psychiatry in order to provide a basic understanding of personality growth and dynamics. The pressure for brief instruction in psychiatry will be great and full of danger in that many physicians now in the Army may desire to practice psychiatry without adequate preparation. These men should be encouraged to attain training and provided with ample opportunities for doing so. In no field of medicine is a purely verbal knowledge so empty and misleading as in psychiatry. Actual clinical experience and responsibility under supervision is the essence of psychiatric education.

2. The education problem for the specialist in other fields, or for the general practitioner who wishes to develop psychiatric insight and skill, will require a cooperative program between psychiatry and the other specialties. Such a combination should provide concurrent clinical experience in both fields.

3. Your committee suggests that a booklet be prepared for distribution to inquiring medical students and young physicians, delineating the various fields of psychiatry and including the types of jobs available and the opportunities for training.

4. We recommend that the institutes for state-hospital physicians, interrupted by the war, be resumed.

5. Consideration should be given to the educational possibilities of the mutual interchange of psychiatric case-studies between teaching institutions for discussion and criticism, and their publication and periodic

distribution to members of our Association, as well as to interested medical students and representatives of other fields.

FRANKLIN G. EBAUGH, COL. MC, *Chairman*
JOHN C. WHITEHORN, M.D.
JOHN ROMANO, M.D.
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DECEMBER 1944

OUTLINE FOR UNDERGRADUATE TRAINING IN PSYCHIATRY

In a personal communication to the Editors of this BULLETIN the Chairman of the Committee, Col. Franklin Ebaugh, has tersely outlined his concept of the content and technique of undergraduate medical school training in psychiatry, as follows:

Pre-medical Education: The premedical courses should include instruction in anthropology, comparative zoology, sociology and psychology—human, not rats!

First Year: Normal personality growth and development should be the theme. A suggestion as to data for such courses is described in Ebaugh and Rymer's *Psychiatry and Medical Education.* Some material on psychoanalytic theory, especially the psychopathology of everyday life, and some material on the behavior problems of children should be included.

Second Year: Psychopathology should be introduced here with emphasis on the applied aspects of autonomic physiology. The dynamics of anxiety, symptom formation, thinking disorders and behavior disorders should be included. The concepts of functional and organic disorders should be presented and discussed. The general and specific nature of the psychological examination and description of mental status should be included. The general idea of adaptation and adjustment with corresponding concepts of maladjustment and conflict, illness reactions, etc., should follow.

Third Year: In-patient Clinical Psychiatry. Clinical work, predominantly clerkships on psychiatric, medical and wards of other divisions. *Minimal* didactic work, development of examination techniques with close supervision, teaching in small sections, close correlation with medical teaching with overlapping of clerkship schedules. Clinics and case demonstrations for third and fourth year students. Emphasis on psychoneuroses and psychosomatic disorders.

Fourth Year: Out-patient Clinical Psychiatry. This should involve demonstrations and supervised instruction in the treatment and management of outpatient cases with follow-up, psychotherapy instruction, cooperation with psychiatric social workers. It should also include consultation and cooperative therapy material from the medical, surgical, orthopedic and other out-patient clinics.

BOOK REVIEW

Hypnotherapy. By Margaret Brenman, Ph.D., and Merton M. Gill, M.D. Published by the Josiah Macy Jr. Foundation, New York, 1944, Review Series Volume II, #3, pp. 96.

Reviewed by Lawrence S. Kubie, M.D.

This is far more than an abstract of the literature of hypnotherapy of the last fifty years. It is rather a critical and judicial survey of the field, a *vade mecum* for every clinician and investigator in psychology and psychiatry. Rarely has the reviewer seen a better blend of objective summary and critical appraisal of the work of others. Each chapter is something of a gem of exposition. The five chapters cover the main problems of hypnotherapy; and the literature lists sample broadly every important contribution to the field. The chapters take up the historical development of hypnotherapy, the methods of inducing and of terminating the hypnotic state, the problem of the susceptibility to hypnosis, the various components and forms of therapeutic procedure under hypnosis, the theory of hypnosis, and a statement of urgent current problems.

The booklet does not pretend to be an exhaustive treatise; yet it is so clear and concise that one may doubt whether a volume several times its size could have contained more valuable information or more illuminating suggestions. Every psychiatrist owes a debt of gratitude to the authors, and to the Josiah Macy Jr. Foundation which made possible this publication.